PHYSICAL ABUSE

1. DEFINITIONS OF PHYSICAL ABUSE:

Any physical injury inflicted on a child other than by accidental means by those responsible for his care, custody, and control except that discipline including spanking, administered in a reasonable manner shall not be construed to be abuse.

2. PHYSICAL AND MEDICAL INDICATORS OF PHYSICAL ABUSE:

The indicators of child abuse and neglect vary. No child or caretaker will exhibit all of the physical or behavioral indicators listed, and some of the indicators are contradictory. The behavior of an abused or neglected child and other family members may be sporadic and unpredictable. Indicators should be used only as a general guide. The presence of multiple indicators or the pervasiveness of any one behavioral indicator warrants close scrutiny by the worker.

SURFACE SKIN MARKS

LOCATION: The location of the injury is a significant criterion which can aid identification of its origin. Injuries to the thighs, calves, genitals, buttocks, cheeks, earlobes, lips, neck and back are more likely a result of abuse than injuries to the elbows, knees, shins and hands, which are frequently incurred accidentally. In the younger child, bruises over the bony parts of the child's body (i.e., chin and forehead) are common sites for falling injuries. However, bruises to any infant should be particularly suspect given his or her limited mobility and opportunity to harm himself or herself.

OBJECTS CAUSING SKIN MARKS: The shape of a surface skin mark or patterns of skin marks provide other clues to origin. Bruises or welts which have distinct configurations, appear in clusters, form regular patterns, or which resemble instruments should be immediately suspect. Examples of objects which cause distinct surface skin marks include:

- belts, belt buckles, ropes and straps;
- electrical cords;
- hands (palms and fists), feet, knees and elbows;
- mop or broom handles, sticks or other pieces of wood;
- wire or wood coat hangers;
- hair brushes and combs;

- cooking utensils (i.e., spatulas);
- knives, scissors;
- hot liquids;
- electric appliances (i.e., irons, heating coils);
- radiators;
- lighted cigarettes, matches or lighters;

Marks encircling the child's wrists, ankles or neck may be the result of being tied or restrained. Multiple bruises extending out and/or downward from the corners of the child's mouth may indicate that the child has been gagged. The child who has been grabbed around the torso by another person's hands may show fingerprints in a pattern that clearly denotes the pressure applied - eight fingerprints on one side of the torso and two thumb prints on the other side.

BRUISES, LACERATIONS AND ABRASIONS: Multiple bruises on various parts of the body and in various stages of healing should receive particular attention. One way to determine the approximate age of a given bruise is by the color. The following table[1] lists the color of bruises and associated age.

Age	Color
0-2 days	red and bluish and swollen, tender
0-5 days	red, blue, purple
5-7 days	green
7-14 days	yellowish
2-4 weeks	clear

The worker should be aware that skin surface redness, which is not swollen and tender, does not always represent the early stage of a bruise. Red marks should be assessed in relation to the reported time of injury.

In addition to color differentiation, injuries incurred at different times will reveal older and newer scars. Bilateral eye and facial injuries (both eyes or cheeks) are of suspicious origin because only one side of the face is usually injured as a result of an accident.

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[1]Richard D. Ruddle, "Missouri Child Abuse Investigator's Manual." Juvenile Specialist Program, Institute of Public Safety Education, College of Public and Community Services, University of Missouri and University Extension Division, May, 1981, p. 42.

The worker should be aware that certain birthmarks, in particular "Mongolian spots," can be mistaken for bruises. "Mongolian spots" are present at birth and generally disappear by the time the child is five years old. These spots are greyish blue, do not change color with time and are commonly located on the buttocks and back. Incidence of the discoloration varies for groups of different racial descent.

The presence of a bruise(s), inflicted upon a child during the course of discipline and/or behavior management, should not always result in investigative conclusion of "Preponderance of Evidence". An investigative finding by "Preponderance of Evidence" that physical abuse exists will be based on the worker's judgment after considering all the evidence including the description of the incident causing the bruise provided by the child, alleged perpetrator and witnesses. The following factors should be considered when evaluating whether a bruise represents physical abuse:

- How bruise was inflicted (open hand, paddle or instrument);
- Location of bruise;
- Severity of bruise;
- Age of child;
- Child's behavior posed a risk to himself or others.

Each incident of bruises inflicted upon a child as the result of discipline/behavior management must be carefully assessed based on: evidence, observations and the above factors.

BITE MARKS: In many cases bite marks should be suspected as the product of abuse or neglect. Although the opinion of a physician or dentist will be needed to firmly identify their origin, workers should be able to make preliminary identifications. A bite will be evidenced by a mark the shape of the cutting edges of the teeth. It may be seen alone or in conjunction with other marks, including a suck mark and/or a thrust mark. The suck mark ("hickey") is a result of the skin being pulled into the mouth by pressure. The thrust mark is caused by a tongue pushing against the skin trapped behind and between the teeth. Bite marks are egg shaped, and clear or contain the suck or thrust mark in the center.

Human bite marks differ in a number of ways from those of animals (including dogs, cats and rodents), which are the bite marks most commonly seen by investigators. In general, animal bites have a narrower arch form (shape) than human bites, leave deeper and narrower marks, and tend to have a ripping rather than crushing effect. Severe animal bites may resemble surgical incisions.

Whether human bite marks are inflicted by an adult or a child can be determined by a trained medical or dental examiner by the size of the impression made by the cutting edge of the teeth. Time is an important factor in accurately diagnosing these marks, so workers should immediately secure medical opinions for this type of injury.

MOUTH INJURIES: Workers may observe the results of trauma to the child's mouth, including broken teeth, lip injuries or tears to the frenum (the fold of skin under the tongue). The latter may be the result of the forcing of an object (i.e., spoon, baby bottle) into an infant's mouth.

Although it is possible for a toddler to accidentally incur such an injury after beginning to walk, infants less than six months old are unlikely to experience such accidental injuries. Children between the ages of two and five are not likely to accidentally tear the frenum because they move about more steadily and are less inclined to fall into objects (i.e., furniture) in a manner that would cause such a tear. Lip injuries can be accidental but can also be the result of a forcible blow to this area with an object (i.e., hair brush). Similarly, teeth may be broken accidentally or as the result of a blow to the mouth with an object (i.e., fist, stick).

BURNS

The extent and characteristics of burn injuries reflect the way the injury occurred. For example, cigarette, match tip, or incense burns produce circular lesions with blisters and ulcers. A lesion is an injury to the body from any cause that results in damage or loss of structure or function of the body tissue involved. Old burns are seen as pigmented scars. The palms, soles, torso and buttocks are the most common sites of these burns.

DRY CONTACT BURNS: Dry contact burns from forced contact with devices or instruments which conduct heat (i.e., irons, heating coils, radiators) usually produce second degree burns which do not form blisters. The injury resembles the contour and shape of the instrument. It is unlikely that an accidental fall against one of these objects will cause an injury of this severity because the child would not remain in contact with the device for more than an instant.

SCALDING: Scalding burns are a result of dipping a child into hot liquid or pouring it over the skin. The burn appears uniform in those areas which were exposed to the hot substance with a line separating the burned area from the unburned skin. "Stocking" burns refer to the injury that results when the child's feet are submerged in a hot liquid. "Glove" burns are caused when the child's hands are forcibly submerged in a hot liquid. Another type is a "dunking" burn, in which the scalding injury is to the feet, buttocks and perineum (i.e., the area between the anus and the posterior part of the external genitalia) corresponding to the child's posture during submersion. Splash marks may not be evident because the child's movement has been constrained. On occasion, an area of skin within a submersion burn will show no injury. This can happen when the

submerged part of the child's body is pressed against the bottom or side of the container (i.e., tub).

These burns are often associated with discipline for "accidents" during toilet training. The degree of injury will vary with the temperature of the liquid and the length of time exposed to it. For example, prolonged exposure to bath water (105°-110°) will not cause burns, while exposure to 158° water, even for one second, will produce third-degree burns.

BURNS FROM CIGARS, CIGARETTES, OR FLAMES: Cigar or cigarette burns may appear separately or in a series. These circular burns are usually inflicted on the palms of the hands, the arms, the soles of the feet, or the scalp. Burns from matches or gas stoves may result from holding the child's hands, feet or other body parts over the flames.

CHEMICAL BURNS: Caustic burns may result from chemicals, such as acids, being splashed or poured on the child.

HOT NEEDLE BURNS: Burns resembling tattoo marks of initials, words or pictures are usually inflicted with a hot pin, needle or other sharp and pointed object.

BURN CLASSIFICATIONS:

- First Degree - The burn is limited to the outer layer of skin;
- Second Degree - The damage extends through the outer layer of the skin into the inner layers. Blistering will occur within 24 hours;
- Third Degree - The skin is destroyed and the damage extends into underlying tissues, which may be charred or coagulated;

  Infected burns may indicate a delay in seeking treatment.

HEAD INJURIES

Violent pulling of a child's hair may cause bleeding under the skin surface, swelling of the scalp, and the simultaneous loss of hair resulting in bald spots or patches.

Subdural hematoma, bleeding between the brain and the skull, is caused when the vein bridging the two is torn. This injury can result from a direct blow to the head or violent shaking. Although medical examinations and x-rays are needed to diagnose all symptoms, the presence of swelling and bruises to the scalp, bleeding of the eye, vomiting, seizures, coma or loss of consciousness should alert the worker to the possibility of this injury. Finger-tip encirclement bruises around the torso, or bruises to the skin located over the center of the shoulder

bone (back) and the center of the collar bones (both sides) and the absence of a skull fracture with the above listed symptoms may indicate that the harm resulted from violent shaking.

INTERNAL INJURIES

Blows (i.e., punches, kicks) to the child's chest or abdomen may cause internal injuries. Diagnosis of these injuries will require medical examination but can sometimes be detected by the worker. Tenderness or swelling of the skin or vomiting may signal the presence of these injuries. The child with internal injuries may appear pale, have an anxious expression, be cold, semi-comatose and perspiring freely. The child may report having experienced intense pain which may diminish over time.

A variety of fractures can result from trauma to the child's bones. Medical and x-ray examinations are necessary to diagnose these injuries. Observable symptoms include swelling, tenderness, the child's inability to move a limb, or protrusion of the bone(s) through the skin surface.

There are many types of fractures, the most common being:

- Simple - the bone is broken, but there is no external wound;
- Compound - the bone is broken, and there is an external wound leading to the site of fracture, or fragments of bone protrude through the skin;
- Complicated - the bone is broken and has injured some internal organ, such as a broken rib piercing a lung;
- Comminuted - the bone is broken or splintered into pieces;
- Spiral - twisting causes the line of the fracture to encircle the bone in the form of a spiral.
- Skeletal injuries that may indicate abuse include:
  - Spiral fractures - fractures that wrap or twist around the bone shaft
  - Corner fractures of the metaphyseal (long bones) -splintering at the end of the bone
  - Epiphyseal separation - a separation of the growth center at the end of the bone from the rest of the shaft, and periosteal elevation - a detachment of the periosteum (i.e., surface layer of the bone and membrane of connective tissue from the shaft of the bone with associated bleeding). These injuries may be caused by twisting or pulling.

POISONING

A child may be neglectfully, accidentally or intentionally poisoned from the ingestion, inhalation, injection or absorption of substances which interfere with the body's normal physiological functions. In addition to dangerous chemicals (i.e., cleaning fluids), almost all substances can be poisonous if consumed in sufficient quantity. An excessive dosage of even common substances, such as aspirin or alcohol, can be poisonous. A medical opinion should be obtained to confirm this diagnosis.

DISCIPLINARY ACTIONS

A variety of disciplinary techniques utilized by parents and caretakers may, by the standards of the worker, appear inappropriate. Other disciplinary techniques are considered bizarre by most any community's standard, i.e., locking a child in a closet or tying a child in a bed for extended periods of time. The worker should carefully evaluate each incident of inappropriate and/or bizarre discipline to determine if it resulted in abuse or neglect and if so, which category of abuse or neglect. The following factors should be considered when evaluating reported incidents of abuse or neglect resulting from disciplinary actions:

- The age and physical/psychological/emotional development of the child;
- The frequency and/or duration of the disciplinary action;
- The physical/psychological/emotional effect the discipline had on the child's safety and well-being;
- Ethnic and cultural standards and practices of the family.

3. BEHAVIORAL INDICATORS OF PHYSICAL ABUSE:

Behavioral indicators of physical abuse may exist independently or in conjunction with physical indicators. Behavioral indicators of physical abuse in the child include:

- Reacts with fear or aggressiveness to being touched, whether the touch is playful, supportive or restraining
- Appears wary of adult contact
- Appears to be or states that (s)he is frightened of the parents or other persons
- Appears to be afraid to go home or to another familiar location

- Seems to feel deserving of punishment
- Demonstrates apprehension when other children cry
- Behaves provocatively and appears to push encounters to the point where others physically maltreat him or her
- Behaves manipulatively to get attention
- Indiscriminately seeks affection
- Appears to have a poor self-concept
- Appears to have a vacant or frozen stare
- Remains very still while visually surveying the surroundings
- Responds to questions in monosyllables
- Seems capable of only superficial relationships
- Exhibits behavioral extremes, including extreme aggressiveness or extreme withdrawal
- Is physically aggressive with no provocation
- Exhibits assaultive behaviors (physical assaults or homicide attempts)
- Is involved in fire setting, compulsive lying, compulsive stealing, compulsive destruction of property or vandalism, or other delinquent acts
- Runs away and appears reluctant to return home when found
- Exhibits precocious maturity
- Wears long sleeves or other cover-up clothing to hide injuries
- States that he or she has been physically abused

BEHAVIORAL INDICATORS OF A PHYSICALLY ABUSIVE CARETAKER INCLUDE

- Seems unconcerned about the child
- Perceives the child as "bad," "evil," a "monster," a "witch," or "different"

- Offers an inadequate or illogical explanation or has no explanation for the child's injury
- Gives different or contradictory explanations for the same injury
- Attempts to conceal the child's injury or to protect the identity of a person the caretaker says is responsible
- Takes an unusually long time to obtain medical care for the child
- Takes the child to a different doctor or hospital for each injury
- Does not visit the child in the hospital
- Does not ask about follow-up care
- Disciplines the child too harshly considering the child's age, condition, or what the child did
- Abuses alcohol or other drugs
- Has a history of physical abuse as a child

4. TYPES OF EVIDENCE:

Evidence is collected by law enforcement personnel, Children's Division (CD) and multi-disciplinary team members and used as both physical and credible verbal evidence to document the worker's investigative conclusion. Evidence for reports of physical abuse may include any one or all of the following:

- Child's statement;
- X-rays;
- Photographs;
- Witness statement;
- Licensed medical practitioner's statement;
- Police reports;
- Worker's observation;
- Instrument/object used to inflict injury (to be obtained by law enforcement personnel);

- Perpetrator's statement;

Chapter 210, RSMo requires the investigator to conduct a thorough investigation. To that end, investigators are allowed to contact anyone with information relevant to the CA/N report without the knowledge and/or consent of the subjects. This includes interviewing the child without the knowledge and/or consent of the parent. When the child is seen without parental consent, every effort should be made to involve the parents as quickly as possible.

VISIBLE SIGNS

Visible signs are those observations made by the worker during the course of the investigation. Visible signs include, but are not limited to: the size, shape and location of an injury, behavioral indicators of family members, and physical condition of the family home.

5. OPERATIONAL DEFINITIONS:

PREPONDERANCE OF EVIDENCE: A finding that physical abuse has occurred or is occurring, founded on the observation of visible signs, physical and/or credible verbal evidence provided to the investigator by the child, perpetrator or witnesses in accordance with the definition of physical abuse and which is supported to a degree of evidence that is of greater weight or more convincing than the evidence which is offered in opposition to it or evidence which as a whole shows the fact to be proved to be more probable than not.

Related Subject: Section 2, Chapter 4, Attachment X Preponderance of Evidence

UNSUBSTANTIATED-PREVENTIVE SERVICES INDICATED: A finding of Unsubstantiated-Preventive Services indicated is appropriate when insufficient visible signs, physical and/or credible verbal evidence exist, but where the investigator determines that indicators are present which if unresolved, could potentially contribute to child abuse/neglect.

UNSUBSTANTIATED: A finding of unsubstantiated is appropriate where insufficient physical or credible verbal evidence exists and where few or no indicators are identified and the worker has not identified a specific threat exists for the child.

INVESTIGATIVE CONCLUSION: This is determined after collecting and reviewing all evidence and/or indicators obtained during the course of the investigation. If there is a finding by a “preponderance of evidence” that child abuse and neglect exists the investigative conclusion will be "Preponderance of Evidence." If the evidence is inconclusive, but there are sufficient indicators to suggest a potential for abuse/neglect to a child, the investigative conclusion

(determination) will be "Unsubstantiated-Preventive Services indicated." Lacking evidence and sufficient indicators, the investigative conclusion will be "unsubstantiated."

PRIORITY STATUS: This is to be determined based on the degree of risk to the child and the immediacy of the treatment needs. In a large part, this is based on the investigator's judgment and knowledge of the family situation.

INVESTIGATIVE RECORDING: Shall be completed in a summarized narrative style on the CPS-1. It should be written in a clear, concise, easily understood manner and include but is not limited to the following components:

- A chronological listing of who, when, where each subject and/or collateral was contacted and the content of the interviews;
- A brief description of all credible verbal and/or physical evidence provided to the worker during the investigation;
- A statement justifying the investigators investigative conclusion i.e., Preponderance of Evidence, Unsubstantiated-Preventive Services indicated or unsubstantiated;
- A brief description of "reasonable efforts" used by the worker to prevent removal of the child; and/or
- Documentation for the reason services were not provided when a child is placed in emergency alternative care.

MEMORANDA HISTORY: CS03-51, CD04-79